Defining deviation: the peer professional opinion defence and its relationship to scope expansion and emerging non-medical health professions

*Jon Wardle**

*Jon Wardle, BHSc (ACNM), MPH (Qld), M Hlth & Med Law (Melb), PhD (Qld), Chancellor's Research Fellow, Faculty of Health, University of Technology Sydney. The author would like to thank Professor Bill Madden (Slater and Gordon, Melbourne Law School, University of Western Sydney and Queensland University of Technology) for his comments and assistance in the preparation of this article.

Abstract

The law imposes a duty to exercise reasonable care and skill in the provision of professional advice and treatment on all health practitioners, which in Australia is assessed via a modified *Bolam* principle. In an era of medical dominance this standard was clearly related to the standards of the medical profession. However, the evolving nature of the Australian health workforce has fuelled speculation as to how non-medical professions are assessed to be practising in accordance with established standards. This article explores the peer-professional defence in relation to new, emerging and established non-medical professions practising in areas that were not historically part of their remit, and finds that individual health professions – even those who do not possess traits historically defined by professionalism - have ultimate discretion in determining the standards by which they are assessed, though such standards may be rejected by courts if they are deemed irrational.

Introduction

The law imposes a duty to exercise reasonable care and skill in the provision of professional advice and treatment on all health practitioners[1]. The standard by which such reasonable care and skill has been measured in recent times was against the *Bolam* principle, from the English case *Bolam v Friern Barnet Hospital Management Committee*[2], which placed primacy of importance on the accepted nature of treatment within the medical profession. This was explained in *Sidaway v Governors of the Bethlehem Royal Hospital and Maudsley Hospital*[3]:

> *"A doctor is not negligent if her acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of clinical judgment."*[4]

In *Roger v Whittaker*[5] the Australian courts confirmed their rejection of the *Bolam* principle in determining the standard of care, at least in giving advice or information, meaning that professional standards were influential – though not conclusive – in determining whether the a professional standard was relevant, instead stating that this was a matter for the court. This 'half-rejection' was explained in more detail by Gleeson CJ in the case *Rosenberg v Percival*[6]:

> *"… the relevance of professional practice and opinion was not denied; what was denied was its conclusiveness. In many cases, professional practice and opinion will be the primary, and in some cases it may be the only, basis upon which a court may reasonably act. But, in an action brought by a patient, the responsibility for deciding the content of the doctor's duty of care rests with the court, not with his or her professional colleagues".*

In 2002, building upon the effects of *Roger v Whittaker* and the subsequent 'unsustainable' award of damages in public liability cases, a ministerial meeting on public liability comprising Commonwealth, State and Territory ministers was convened, and agreed to appoint a panel of persons to examine and review the Australian law of negligence[7]. This review, the *Review of the Law of Negligence* was commonly referred to as the *Ipp Report* (hereafter referred to as *Ipp*). A core recommendation of *Ipp* was the recommendation concerning the standard of care in treatment cases (Recommendation 3):

> "*… [T]he test for determining the standard of care in cases in which a medical practitioner is alleged to have been negligent in providing treatment to a patient should be: A medical practitioner is not negligent if the treatment provided was in accordance with an opinion widely held by a significant number of respected practitioners in the field, unless the Court considers that the opinion was irrational."*[8]

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[1] This is most clearly demonstrated by provisions for registered practitioners under the *Health Practitioner National Law Act 2009* (Qld) and its adopted variants across other States and Territories as part of the National Registration and Accreditation System. However, there are also provisions in civil and criminal law for all practitioners, and even legislative provisions such as 'negative licensing' or statutory code of conduct legislation as enacted under section 41A of the *Health Care Complaints Act 1993* (NSW). See Wardle J, "Holding unregistered health practitioners to account: an analysis of current regulatory and legislative approaches" (2014) 22 JLM 350

[2] [1957] 1 WLR 582

[3] [1985] AC 871

[4] [1985] AC 871 at [881]

[5] [1992] HCA 58; (1992) 175 CLR

[6] [2001] HCA 18 at [7]

[7] Panel for the Review of the Law of Negligence, *Review of the Law of Negligence: Final Report* (Commonwealth of Australia, Canberra, 2002)

[8] Panel for the Review of the Law of Negligence , n 7 at 1

By providing the exception to the peer professional defence, *Ipp* highlights that the peer professional opinion defence is influential in determining negligence, but cannot be viewed (as in *Bolam*) as a sole defence in-and-of itself. Madden and McIlwraith describe the post-*Ipp* framework as having three steps: 1) common law, as adjusted by civil liability provisions considers whether the practitioner has been negligent; 2) the statutory 'peer professional opinion' defence allows for consideration of whether the health professional acted in a manner that was widely deemed to be competent professional practice, and; 3) the exception to the defence ("unless the court considers that opinion irrational") allows for treatment that is irrational or unreasonable to not be considered competent practice, simply by virtue of wide professional acceptance[9]. This recommendation was eventually enacted, in various and subtly different forms, by State governments in Australia[10]. However, a number of issues have arisen from the ways in which this recommendation has been enacted. For example, there is little consideration of what the terms 'significant', 'professional', 'competent' or 'respected' may mean. Additionally, in their implementation, State governments had not provided clarity on the health professionals to whom these provisions applied in the legislation.

The changing nature of the Australian health workforce

Beyond issues of (relatively) more legal clarity such as breach of duty, Madden and McIlwraith highlight that the issue of what constitutes competent or accepted practice remains speculative, and requires further development of law in this area[11]. Fuelling such speculation is the fact there has been increased scope expansion across the health practitioner spectrum. The Australian health workforce is rapidly changing to meet the evolving needs of contemporary health system and health consumers. Task substitution and task delegation has now become a focus of Australian health policy and health workforce planning[12], and it has also been proposed that health practitioners need to work towards the "top of their licence" by performing health tasks that, whilst legally and technically allowable, were not previously part of standard practice[13]. Task substitution proposed by Australian government reports have been for high-level tasks once restricted to medical practitioners, including reporting pathology and X-rays (scientists and medical imaging technologists replacing pathologists and radiologists), administering anaesthesia (nurse anaesthetists replacing anaesthetists) and laryngoscopy (speech pathologists replacing ENT surgeons). Some commentators have already noted that such task substitution is likely to have significant impact on professional liability[14]. It is also likely that such delegation and substitution will have significant effect on what constitutes both competent and accepted practice, as health professions begin to take on roles once reserved, monopolised or restricted to other professional groups.

However, such task substitution is not always directed by health policy concerns, nor directed by government. Within established professions too, there has also been much voluntary change in what constitutes normal 'scope of practice'. The increasing number of dieticians entering unsupervised private practice in one-on-one clinical settings[15], for example, may negate previous arguments that dieticians did not require statutory regulation as their profession was focused on hospital practice under the supervision of regulated health practitioners. Growing specialisation and utilisation of niche health professions has also had significant impact on the way in which healthcare is delivered. For

[9] Madden B and McIlwraith J, *Australian Medical Liability* (2nd ed, LexisNexis Butterworths, Sydney, 2013) p135

[10] It was not enacted by Territory governments

[11] Madden and McIwraith, n at 135

[12] Duckett S, "Interventions to facilitate health workforce restructure" (2005) 2 Aust New Zealand Health Policy 14

[13] Murray RB, "Do available predictions of future medical workforce requirements provide a sensible basis for planning? No" (2012) 197 Med J Aust 267

[14] Keany M, "Health workforce redesign in Australia: implications for health care professional liability and the provision of professional indemnity insurance" (2008) 15 JLM 494

[15] Brown L, Capra SM, Williams L, "Profile of the Australian dietetic workforce: 1991-2005" (2006) 63 Nutr Diet 168

example, increased specialisation in mental health care has resulted not only in psychiatry and psychology entering new fields of practice, but also in the emergence of multiple mental health disciplines practising (and increasingly integrated) in the arena once monopolised by psychology and psychiatry, many of whom may themselves fulfil the current criteria for future inclusion in a regulatory scheme[16]. Unlike government supported scope expansion or task substitution, which may bring with it protective legislative arrangements for this increased scope[17], this voluntary scope expansion brings no such protections, and the responsibilities, standards and duties associated with such action remain unclear. Additionally, although scope expansion may be traditionally viewed as being directed by governments or institutions to improve efficiency[18], an increasingly consumerist model of healthcare has given the consumer greater power in shaping the way healthcare is delivered. One clear example of this phenomenon of this is the rise of complementary health services[19], which now account for half the health practitioner numbers providing primary point-of-care service, half the total health consultations and half of all out-of-pocket health spend in Australia[20]. However, whilst it is estimated that one-third of Australian patients who seek the services of a complementary medicine provider now utilise this therapist as their primary care practitioner[21], there has been scant examination of what this emerging yet significant scope of practice means from a medico-legal perspective.

In addition to scope expansion amongst established health occupations – which could reasonably be considered health 'professionals' even under the older criteria – in some instances cost and productivity initiatives have necessitated that work previously done by highly-trained and regulated workforces has been replaced by lower cost unregistered providers (such as the administration of scheduled medicines by carers rather than medical practitioners or registered nurses)[22]. Additionally, as the Australian health system evolves new health disciplines may develop, which may develop an established role before they are fully incorporated into statutory regulatory arrangements[23]. The

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[16] Freckelton I, "Trends in Regulation of Mental Health Practitioners" (2008) 15 Psychiatr Psychol Law 415

[17] For example, see the government temporary arrangements to provide independent midwifery professional indemnity insurance. See Forrester K, "Nurses, midwives and the requirement for "appropriate" professional indemnity insurance" (2012) 19 JLM 678

[18] Most procedural examples of task delegation would fit this example – e.g. the transfer of foot surgery to podiatric surgeons

[19] Another example is the fitness and wellness coach industry, which has been discussed in Keyzer P, Coyle I, Dietrich J et al, "Legal risk management and injury in the fitness industry: the outcomes of focus group research and a national survey of fitness professionals" (2014) 21 JLM 826

[20] See Xue C, Zhang A, Lin V, et al, "Complementary and alternative medicine use in Australia: a national population-based survey" (2007) 13 J Altern Complement Med 643 for data which suggests patient out-of-pocket costs and number of consultations with complementary medicine providers are now comparable to those of conventional medical products and conventional medical providers. See also Wardle J, Adams J, Soares Magalhães R and Sibbritt D, "Distribution of complementary and alternative medicine (CAM) providers in rural New South Wales, Australia: a step towards explaining high CAM use in rural health?' (2011) 19 Aust J Rural Health 197 for data which suggests that in some areas of Australia complementary health providers offering primary care services to patients may in fact outnumber conventional primary care providers.

[21] For evidence of this trend See Chow R, "Complementary medicine: impact on medical practice" (2000) 41 Curr Ther 76; Grace S, Vemulpad S and Beirman R, "Training in and use of diagnostic techniques among CAM practitioners: an Australian study" (2006) 12 J Altern Complement Med 695. Like other professions such as nursing, this primary care role seems particularly pronounced in rural areas. See Wardle J, Adams J and Lui C, "A qualitative study of naturopathy in rural practice: A focus upon naturopaths' experiences and perceptions of rural patients and demands for their services" (2010) 10 BMC Health Serv Res 185

[22] The use of unregistered assistants-in-nursing and personal care attendants to perform tasks that were once the domain of enrolled and registered nurses is one example, as is the increasing use of counsellors and psychotherapists in place of psychologists. See Australian Nursing Federation, *Balancing risk and safety for our community: unlicensed health workers in the health and aged care systems* (Australian Nursing Federation, Canberra, 2009) p 3.

[23] For an example of such a profession, see the discussion around training and regulatory requirements for the Physician Assistant workforce in Health Workforce Australia, *The potential role of Physician Assistants in the Australian context* (Health Workforce Australia, Adelaide, 2011) p 1.

increasingly multidisciplinary nature of Australian healthcare delivery has also necessitated the development of new health disciplines and increased roles for nascent health disciplines, for whom regulatory structures and legislative arrangements will need to be considered, but for whom there has been little policy, legislative or regulatory attention. This also includes the increased professionalization and integration of "professional assistants" into healthcare in Australia and internationally[24], with some of these "professional assistants", such as physician assistants, being actively promoted by Australian government to fill primary care gaps in underserved communities[25]. It is estimated that over 200,000 unregistered health practitioners are providing health services in Australia[26], however, as unregistered health practitioners existing outside formal regulatory structures it is difficult to estimate the true size of the sector[27].

Most attention in medical liability has, understandably, focused on the medical profession, and therefore in the few cases where such questions have been raised[28] they've been answered in relation to this profession. In other well-established professions, such as nursing or dentistry, this may be also relatively clear[29]. However, when existing professions expand their scope of practice beyond traditional roles and start performing roles previously restricted to other practitioner groups[30], these provisions become much less clear. Additionally, for new and emerging professions, including the rise of 'unorthodox' complementary and alternative therapists in Australia, these standards are less clear. Although medical opinion was historically a significant influence on non-medical health professional practice this too appears to be waning, with scope expansion of some practitioners[31] and inclusion of some practitioners into national registration scheme[32] occurring even when there is significant opposition from the medical community. Previous rules, assumptions and protocols for considering what constitutes a health profession or professional practice within a health profession may no longer be relevant to changes in Australian civil liability law. In order to examine the impact of scope expansion, task substitution and emerging roles of new provider types on the peer professional opinion defence in medical litigation two primary questions need to be answered. Initially, it must be determined which health occupations current civil liability provisions relating to medical negligence extend to. Once it has been determined, it needs to be considered what the standards of peer professional opinion must be.

Who are the professionals?

[24] Edmond N, Arada K and Gaudoin R, "The 'assistant practitioner' as 'associate professional'? Professional development of intermediate roles in health and social care and education" (2012) 34 Stud Cont Educ 45
[25] Kurti L, Rudland S, Wilkinson R, et al "Physician's assistants: a workforce solution for Australia?" (2011) 17 Aust J Prim Health 23
[26] Australian Health Ministers' Advisory Committee, *Final report: Options for regulation of unregistered health practitioners* (Australian Health Minister's Advisory Council, Adelaide, 2013) p 60
[27] Australian Health Ministers' Advisory Committee, n 26, at 60. For one profession alone, naturopathy, estimates range from 3,000 to 15,000 practitioners, though most indicating a practice population of at least 10,000. Similar variation in estimated practitioner populations was observed across many other (though usually smaller) health disciplines. Examples of such practitioners include arts therapists, assistants-in-nursing, audiologists, counsellors and psychotherapists, dental technicians and oral health technicians, diabetes educators, dietitians, music therapists, perfusionists, social workers and speech pathologists. These practitioners are currently employed in government health schemes, hospitals and in many instances attract Medicare subsidies or other government subsidies for their private services. Some unregistered health practitioners are even entrenched in legislation, for example various pieces of Australian legislation (such as legislation governing adoption or requirements upon receiving a positive HIV test) specifically require a person seek counselling services.
[28] For example, in the *Ipp Report*
[29] For example, there are national competency standards in these professions.
[30] For example, nurse physicians taking on primary care roles
[31] Such as the attempts to allow for increased scope of nurse practitioners, for pharmacists to administer vaccinations and for optometrists to perform tasks once restricted to ophthalmologists.
[32] For example, Chinese medicine. For further detail on the perceptions of the Australian medical community to Chinese medicine see Wardle J; Sibbritt D; Adams J, "Referral patterns to Chinese medicine practitioners by New South Wales rural and regional general practitioners: a research survey" (2013) 8 Chin Med 8

A key issue in determining the standards that are applied in determination of medical negligence via the departure of professional standards in the post-*Ipp*, a key consideration is who is the professional group? Further complicating the definition of reasonable or competent standards of practice for health professions is the emerging trend of health legislation that no longer limits discussion of 'professions' to application to medical practitioners – to whom *Bolam* almost exclusively applied – and encompasses a broad range of practitioners. In fact most legislation does not limit itself to any specific practitioner subtypes. In New South Wales, South Australia and Tasmania no attempt at all is made to define what a health 'professional' is[33]. Queensland and Victoria only extend this definition to 'a person practicing a profession'[34]. Western Australian legislation makes an attempt to define the specific groups that can be considered 'health professionals', but then, under Section 5PA(b) includes 'any person who practises a discipline or profession in the health area that involves the application of a body of learning'[35]. The professionalization movement has long been criticised as a political movement for professional promotion through extension of power, monopoly and influence, rather than one of public safety[36]. Additionally, many of the attributes of recognised health professions are no longer unique to those few professions which do manage to achieve formal recognition of their professional status, and are often shared by disciplines without this status[37]. The *Ipp* Committee acknowledged the political nature of this designation, and in fact deliberately opted out of making a formal suggestion or recommendation as to what occupational groups should constitute a profession for the purposes of medical litigation, noting that it was a political decision for governments to make or for courts to determine[38]. The Ipp Committee was, however, able to make a clearer statement on the use of the word 'respected', which it stated was to be used primarily "to ensure that the Commonwealth government has made attempt to define professionals under the *Australian and New Zealand Standard Classification of Occupations* – which is meant to inform how definitions are used in legislation – and defines professionals for this purpose rather broadly:

> *"Professionals perform analytical, conceptual and creative tasks through the application of theoretical knowledge and experience in the fields of the arts, media, business, design, engineering, the physical and life sciences, transport, education, health, information and communication technology, the law, social sciences and social welfare"*[39].

The declining importance of statutory registration in determining health professional status

This broad definition has occurred as the changing nature of the Australian health landscape has resulted in more health practitioner types practising as part of the healthcare milieu than ever before. The nature of existing regulatory arrangements informing definition as a 'professional' has also changed considerably. The health practitioner sector regulatory regime in Australia began to liberalise in the 1990s as part of the Competition Review which arose out of the Hilmer Report[40], which recommended the review of state-based legislation (including health practitioner legislation) to avoid

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[33] Madden and McIwraith, n 9 at 145
[34] Madden and McIwraith, n 9 at 145
[35] Madden and McIwraith, n 9 at 145
[36] Kerridge I, Lowe M and Stewart C, "Professionalism" in *Ethics and Law for the Professions* (3rd ed, Federation Press, Sydney, 2009), Ch 7, pp112-130; Wear D and Kuczewski M, "The professionalism movement: can we pause?" (2005) 4 Am J Bioethics 1
[37] For example, dietitians although do not have registration but have a distinct body of learning delivered by accredited education programs, government reimbursement for the services and are often employed in senior decision-making roles in the public health sector
[38] Panel for the Review of the Law of Negligence, n 7 at [3.25-3.31] p43
[39] See Australian Bureau of Statistics, Australian and New Zealand Standard Classification of Occupations, cat no. 1220.0, version 1.2 (26 June 2013) http://www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/4AF138F6DB4FFD4BCA2571E200096BAD?opendocument
[40] National Competition Policy Review Committee *The Report of the Independent Committee of Inquiry into National Competition Policy* (Australian Government Publishing Service, Canberra, 1993) p 189

anti-competitive provisions. This review resulted in a gradual retreat strictly defined scope of practice provisions that had been previously been employed to establish professional monopolies for professional advantage and advancement – and in the process unequivocally cemented that occupation's professional status – and moved towards a greater reliance on 'holding out' provisions via protection of professional titles. This contemporary policy construction of health practitioner regulation as a process of risk management and protection of public safety, and efforts to reduce its use as a tool for developing professional monopolies, is quite different from sociological perspectives which have generally theorised statutory regulation as the state's legitimation and protection of the profession's work (and subsequently their 'recognition' as a profession). These developments have resulted in Australian jurisdictions taking a conservative approach to extending statutory regulation to new health disciplines, and despite increasing scope and prevalence of unregistered health practitioners in the Australian health system – which in the past may have been enough to warrant professional recognition through registration[41] – only a few health disciplines have been formally considered for statutory registration from this time[42].

Increasingly health occupations have not undergone the traditional pathways of professionalization – such as the development and enforcement of practice and entry standards, statutory or voluntary. In fact, a considerable percentage of the total health workforce in Australia now functions in an environment not governed by any form of regulation – the traditional marker of 'entry' into formal recognition of professional status[43] – save that of voluntary (and often ad-hoc and informal) self-regulation[44]. However, reliance on registration status alone to identify which health disciplines are 'professions' is itself fraught, as the issue of health professions registration is often highly controversial and highly politicised[45]. Registered status may also not be permanent: with the introduction of the legislation relating to mutual recognition of registered health practitioners across

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[41] The recognition of chiropractors serves as an example here. The first legislation recognising chiropractic in Australia (the *Chiropractors Act* 1964) arose from acknowledgement of the potential role of chiropractic in filling a gap that current medical care did not provide. This acknowledgement was determined in: Guthrie H (Chair) *The Report of the Honorary Royal Commission appointed to inquire into the provisions of the Natural Therapists Bill* (Western Australian Government, Perth, 1961). Naturopaths, homeopaths and osteopaths were also considered for registration and rejected solely because their scope of practice was not deemed to be valid or unique, and most aspects were 'amply covered by currently registered professionals (medicine)'. A similar approach was taken by Webb E (Chair) *Report of the Committee of Inquiry into Chiropractic, Osteopathy, Homeopathy and Naturopathy* (Australian Government Printing Service, Canberra 1977). In this report registration of chiropractic and osteopathy were recommended as recognition and reward for the increased standards these professions had developed in the past decade. Naturopathy and homeopathy were not deemed to have made the same progress and as such were dismissed.

[42] Aboriginal and Torres Strait health workers, Chinese medicine practitioners, medical radiation therapists and occupational therapists are now part of the National Scheme, with paramedics currently being mooted for inclusion. Naturopaths and Western herbalists have also been formally assessed by the Victorian government as requiring statutory registration, but are not included in the National Scheme.

[43] Kerridge et al, n 36 at 117

[44] Freckelton I, "Regulating the unregistered" (2008) 16 JLM 413

[45] As an example, the only currently unregistered health disciplines (naturopaths and Western herbalists and counsellors and psychotherapists) that have undergone a formal government-commissioned assessment was put forward to the Australian Health Workforce Ministerial Council in 2008 has had consideration delayed until negative licensing has been implemented nationally; whilst the only unregistered health discipline formally being considered (paramedics) was unilaterally put forward for inclusion by the Western Australian health minister in 2010, before a formal assessment against intergovernmental criteria had been made. See Lin V, Bensoussan A, Myers S, McCabe P, Cohen M, Hill S and Howse G, *The practice and regulatory requirements of naturopathy and western herbal medicine* (La Trobe School of Public Health (funded by Department of Human Services), Melbourne, 2005) p 14; Social Development Committee, *Inquiry into Bogus, Unregistered and Deregistered Health Practitioners* (Parliament of South Australia, Adelaide, 2009) p 1; Australian Health Workforce Ministerial Council. *Agenda Friday, 12 February 2010* http://www.ahpra.gov.au/documents/default.aspx?record=WD10%2F4060&dbid=AP&chksum=0NWg8A40kxkC2byk2XEnqw%3D%3D.

State and Territory boundaries in Australia in 1992–93[46], statutory registration arrangements were repealed for some health disciplines that were registered in only some jurisdictions[47], and were not reintroduced. Registered status may also have little relation to the role or integration of health disciplines within the broader health system: many health disciplines[48] that have integrated into the conventional healthcare system via hospital placements or public subsidies for their services have not yet been included in the National Registration and Accreditation Scheme (the National Scheme – empowered by the *Health Practitioner Regulation National Law Act* 2009 (Qld), and its equivalent in other States and Territories), with no formal plans for their future inclusion[49]. Nor does registration status suggest that registered professions have undergone the process of professionalization (as it once did): Some health professions – such as aboriginal and Torres Strait Islander health workers – have been accepted for inclusion into the national registration scheme before standards of training and practice had even been developed for that profession. In this view, although statutory registration of health professionals may list the protection of the health and safety of the public as its primary concern[50], it would appear that it is to longer sufficient to use to identify professions to which such legislative provisions entail.

Traits-based criteria for professional status

Sappideen notes that, in addition to registration status, courts have traditionally adopted a 'traits-based' definition of determining which occupations should and should not be accepted as a profession, whereby individual occupations are assessed by their essential attributes[51]. Whilst she also notes that there is no universal agreement on what these attributes are, Sappideen highlights "professional standards of competence, training and ethics... reinforced by some form of official accreditation accompanied by evidence of qualification"[52] as being the primary requirement traditionally held by courts, whilst the academic literature on professions – which seems also to have influenced court

[46] Under the *Mutual Recognition Act 1992* (Cth)

[47] This included naturopaths, speech pathologists and social workers in the Northern Territory under the *Health Practitioners and Allied Professions Act 1985* (NT) and dietitians in Victoria under the *Dietitians Act 1981* (Vic).

[48] Due to the heterogeneity of unregistered health practices, which range from those performed by well-established long-standing professions with thousands of practitioners integrated into the Australian health system to small non-organised groupings of 'fringe-medicine' service providers, the term 'health discipline' and 'health practitioner' has been used when describing unregistered health practitioner groups and practitioners.

[49] See Australian Health Ministers' Advisory Council, n 1, p 10. Examples of such practitioners include arts therapists, assistants-in-nursing, audiologists, counsellors and psychotherapists, dental technicians and oral health technicians, diabetes educators, dietitians, music therapists, perfusionists, social workers and speech pathologists. These practitioners are currently employed in government health schemes, hospitals and in many instances attract Medicare subsidies or other government subsidies for their private services. Some unregistered health practitioners are even entrenched in legislation, for example various pieces of Australian legislation (such as legislation governing adoption or requirements upon receiving a positive HIV test) specifically require a person seek counselling services.

[50] though this remains the stated aim of registration legislation in Australia, analysis and commentary has questioned whether registration in Australia actually fulfils this promise, or whether it is still largely focused on professional protection and promotion. See Elkin K, "Medical practitioner regulation: is it all about protecting the public?" (2014) 21 JLM 682

[51] Sappideen C, "Bolam in Australia: more bark than bite?" (2010) 33 UNSW LJ 394

[52] Sappideen C, n 51 cites the following court cases that have instilled these definitions: *Commissioners of Inland Revenue v Maxse* [1919] 1 KB 647, 657 (Scrutton LJ); *Currie v Commissioners of Inland Revenue* [1921] 2 KB 332; *Robbins Herbal Instiute v Federal Commissioner of Taxation* (1923) 32 CLR 457; *Carr v Inland Revenue Commissioners* [1944] 2 All ER 163, 166 (Du Parcq LJ); *Holman v Deol* [1979] 1 NSWLR 640, 649; *NRMA v John Fairfax* [2002] NSWSC 563 (26 June 2002), [147]; *GIO General Ltd v Newcastle City Council* (1996) 38 NSWLR 558, 568; *Prestia v Aknar* (1996) 40 NSWLR 165, 184–6 (Santow J); *King v Besser* [2002] VSC 354 (30 August 2002); *Shahid v Australasian College of Dermatologists* (2008) 168 FCR 46, 93 (Jessup J reviewing the authorities). Also adopting a traits based analysis, see Walmesley S, Abadee A and Zipser B, *Professional Liability in Australia* (2nd ed, Lawbook Co, Sydney, 2007) 10–12; Saks M, *Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine* (Routledge, London, 1995), 12

decisions – also puts forward relationships of trust and confidence, high levels of autonomy, significant levels of self-regulation by professional organisations and professed altruism[53]. In the modern multi-disciplinary Australian healthcare sector these qualities are no longer possessed by medicine alone, nor even by only the registered professions. In New South Wales and South Australia, where specific legislation on unregistered practitioners exists via a statutory Code of Conduct[54], both codes contain statements that all practitioners must 'provide health services in a safe and ethical manner', which is described as practising within the scope of their knowledge and training, maintaining expertise and competence in their respective field, and only practising their service in the interests of their client. With national roll-out of a statutory Code of Conduct based on the New South Wales legislation imminent, many of the traits previously reserved for health occupations that were considered to be 'professionals' will – in theory – be expanded to new professions.

However, whilst an exhaustively inclusive definition of who is now considered a 'health profession' encourages accountability of a broader range of health services, it brings with it its own complexities. An obvious example of the complexities and contradictions of trying to determine what is a health profession solely via traits based mechanisms is observed in one of Australia's largest unregistered health practitioner groups – naturopaths. Naturopathy both fulfils and falls short of traditional traits-based criteria. Although generally excluded from public health system, naturopaths have still managed to facilitate a significant role in the healthcare sector, with the discipline already achieved some degree of public professional recognition such as high public utilisation of their services[55] and limited reimbursement by third-party payers[56] (indicating some level trust and confidence). However, professional legitimacy in the eyes of the public is not, nor has not historically been, matched by institutional support for professional status. Previous government reports have derided naturopathy as a 'minor cult system' rather than a valid health discipline[57], and there is significant support in the medical community to remove naturopathy from the university sector and insurance rebates for naturopathic services[58] (indicating that such trust and confidence is not universal). To graduate as a naturopath now requires minimum of a four-year Bachelor degree[59] (indicating an applied body of

[53] Saks M, above n 52 at 12, Kerridge I et al, above n 36 at 117

[54] In New South Wales *Public Health Act 2010* (NSW), s 100 empowers the Code; *Public Health Regulation 2012* (NSW), Sch 3 provides details of the Code of Conduct; In South Australia the relevant legislation is *Health and Community Services Complaints Act 2004* (SA), s56

[55] In Australia, approximately 10% of the population regularly see a naturopath, rising to 16% in complex conditions such as cancer or depression. See Adams J, Sibbritt D and Young A, "Consultations with a naturopath or herbalist: the prevalence of use and profile of users amongst mid-aged women in Australia" (2007) 121 Pub Health 954.

[56] Such as private health insurance rebates

[57] Webb E (Chair) *Report of the Committee of Inquiry into Chiropractic, Osteopathy, Homeopathy and Naturopathy* (Australian Government Printing Service, Canberra 1977). Other inquires have rejected registration for naturopathy until traits-based professional criteria are met in that profession, see Guthrie, n 41; Victorian Parliament Social Development Committee, *Inquiry into Alternative Medicine and the Health Food Industry (Vols 1 & 2)* (Victorian Government Printer, Melbourne, 1986). However, it should also be noted that many other government inquiries have recommended registration of naturopaths when assessed solely in terms of protecting public interest. See Lin, n 45; South Australian Parliament Social Development Committee, n 45; Victorian Parliament Joint Select Committee, *Report from the Osteopathy, Chiropractic and Naturopathy Committee, together with appendices* (Victorian Government Printer, Melbourne 1975). Naturopaths were also once registered in the Northern Territory between 1985 and 1992, however, the registration of this group has always been controversial.

[58] MacLennan A and Morrison R, 'Tertiary education institutions should not offer pseudoscientific medical courses. (2012) 196 Med J Aust 225

[59] It should be noted, however, that this initiative has not come from the naturopathic community, but has been imposed (with significant opposition from many elements within the naturopathic community) in response to the increasing role of these practitioners in the healthcare system. See Community Services and Health Industries Skills Council, *July 2014 Update: Advanced Diplomas of Homeopathy, Naturopathy, Nutritional Medicine and Western Herbal Medicine to be aligned at Bachelor degree level'* <http://www.cshisc.com.au/media/281046/CSHISC_COMMUNICATION_CAH_ADVANCED_DIPLOMAS_July_2014.pdf>

learning) – more than many registered health professions – yet fragmentation and division within the profession– has made it almost impossible to develop national or consistent standards for training or practice within this profession (indicating that the body of learning is not consistent)[60]. The practices of naturopaths have also been assessed against naturopathic standards in both criminal and civil law (indicating some degree of legal recognition of naturopathic body of learning), though such assessment has not been limited to naturopathic standards alone (indicating that naturopathic standards alone are not recognised completely)[61]. There are few restrictions on naturopathic practice and approximately one –third of naturopathic patients use their naturopathic provider as a primary care practitioner (indicating autonomy)[62], yet this autonomy only exists in the private health sector, and naturopaths have little authority in the public health care system. There are over 80 professional associations representing naturopaths[63] (indicating failed attempts at adequate self-regulation) yet they are required to join a professional association in order to meet private health insurer or Therapeutic Goods Administration requirements and sales tax exemption related to their practice[64] (indicating higher levels of collectivism and organisational development through professional association membership than most registered practitioner types).

However, these complexities, which ordinarily would make classification as a 'profession' difficult, may be rendered moot by the fact that specific elements of legislation now explicitly recognise naturopaths (and other unregistered health occupations) as 'health professionals'. Naturopathy, for example, is listed by the *Australian and New Zealand Standard Classification of Occupations* as a health profession at the highest level (Skill Level 1) under Minor Group 2 ('Health Professionals'). Naturopaths are also recognised using the specific terminology 'recognised professionals' for sales tax exemption (with 21 other health occupations) under Section 38-10 of the *A New Tax System (Goods and Services Tax) Act 1999* (Cth). When developments such as these are considered with other developments, such as the extension of obligating traditional traits-based attributes of professions to all unregistered health occupations under negative licensing legislation implemented across Australia, and the changing role of statutory professional registration, it can be considered that the broad and vague terminology around health professions in civil liability legislation is not an oversight, but rather a deliberate attempt to allow the common law to evolve with the Australian health system, by allowing these provisions to not be solely restricted only to health practitioners specified in legislation, but to any health occupation which plays a significant role in the Australian healthcare system.

Practice issues: what is standard and competent care?

As discussed previously, trends in legislative definition of profession have expanded the potential use of the peer professional opinion defence considerably. Whilst this requirement is only explicitly stated in Queensland and Victorian legislation[65], it is implicit in other State and Territory legislation. The broad remit of who is now classed as a 'health professional' under Australian legislation raises a number of issues. For example, commentators have noted that although these broad statutory definitions may help to explain to whom 'peer professional opinion' defences may apply (i.e. the

[60] Wardle J, Steel A and Adams J, "A review of tensions and risks in naturopathic education and training in Australia: a need for regulation" (2012) 18 J Altern Complement Med 364
[61] Wardle, n 1 at 353
[62] Grace S, Vemulpad S and Beirman R, "Training in and use of diagnostic techniques among CAM practitioners: an Australian study" (2006) 12 J Altern Complement Med 695. Like other professions such as nursing, this primary care role seems particularly pronounced in rural areas. See Wardle J, Adams J and Lui C, "A qualitative study of naturopathy in rural practice: A focus upon naturopaths' experiences and perceptions of rural patients and demands for their services" (2010) 10 BMC Health Serv Res 185
[63] Bensoussan A, Myers S, Wu S, O'Connor K, "Naturopathic and Western herbal medicine practice in Australia-a workforce survey" (2004) 12 Complement Ther Med 17.
[64] Australian Register of Naturopaths and Herbalists, *Submission to the consultation on options for regulation of unregistered health practitioners* (Australian Register of Naturopaths and Herbalists, Brisbane, 2011)
[65] *Civil Liability Act 2003* (Qld) s 22; *Wrongs Act 1958* (Vic) s 59(1); *Civil Liability Act 1936* (SA) s 41(1) acceptance by the 'same profession as competent professional practice'

actual reach of civil liability legislation), they do little to inform how liability due to negligence may be determined. As the relevant peer professional opinion is that of the practitioners within the particular field of the dependent, the broadening of the definition of health professional adds further complexity, as now the courts must consider not only the traditional accepted standards of medical practice, but also the standards that should be applied to non-medical practitioners too. This is further complicated by the expansion of scope by many practitioners, whose contemporary standard practice may not reflect their traditional practice roles. The evolving and changing nature and scope of practice of health practice by specific disciplines is sometimes explicitly considered by judicial bodies and tribunals, though this is largely considered in the context of the suitability of practitioners to re-enter practice, or failure to maintain their practice skills[66].

Where health disciplines are part of a registered profession, the question around what is professional scope of practice is relatively clear. Guidelines, where they exist, could also provide evidence of professional peer opinion where the guidelines are supported by expert evidence as to the relevance in their particular case[67].This replicates disciplinary protocols in non-medical health professions. For example, in cases where nurses have been brought before the tribunal to determine whether they have acted within their scope of practice, national competency standards developed by the Australian Nursing and Midwifery Council have been used to determine what scope of professional practice is[68]. However, utilising these guidelines do have some limitations even in circumstances of established practice, even beyond personal objections by practitioners, in that: as consensus documents they may not accurately reflect individual circumstances, they may be of inconsistent and variable quality or may provide minimum rather than reasonable standards[69]. For many new and emerging professions, they are also likely not to exist, requiring the court to make such judgment on other factors.

The practice must be accepted in the Australian setting

One of the further qualifications to *Bolam* suggested by the ***Ipp***, and adopted by New South Wales, South Australia, Tasmania and Victoria[70], is the requirement that the relevant peer opinion must be widely accepted in Australia. Whilst in relation to medical practice this provision was recommended to ensure that localised or overseas practices that did not have the support of the broader medical profession were not relied upon as evidence[71], for new and emerging professions this may be problematic. Although overseas evidence could in this context be used to determine whether the practice was irrational or unreasonable (and could therefore theoretically garner similar court support as 'professional peer opinion'), it is not admissible on the question of standard of care for the peer

[66] For example, in *Epstein v Nursing and Midwifery Council of NSW* [2011] NSWNMT 4 (9 March 2011): "It has now been some 20 years since the Appellant practised in the capacity of a RN. As summarised above the Appellant has undertaken a significant amount of 'nursing' related work and maintained an interest in the profession of nursing. During this time the training and education of nurses, in particular RNs, has changed significantly. The responsibilities of a RN have both increased and changed in character. There have been significant changes in the complexity and availability of equipment such as monitors and the like that RNs are expected to utilise. The setting in which RNs work has changed significantly as have the skills and competencies expected of all RNs."

[67] Sappideen C, n 51 at 411; *Greater Southern Area Health Service v Dr Angus* [2007] NSWC 1211 (2 November 2007); *Sydney South West Area Health Services v MD* [2009] NSWCA 343 (21 October 2009).

[68] For example, see *HCCC v Piper* [2014] NSWCATOD 62 (12 June 2014) at [31] where these standards were used in relation to prescription of S4 medications without authority; *Epstein v Nursing and Midwifery Council of NSW* [2011] NSWNMT 4 (9 Mar 2011) at [108] where the tribunal states explicitly that a nurse must limit herself to areas in which they are competent and trained in accordance with the ANMC Code of Conduct and competencies.

[69] Samanta A and Samanta J, "NICE Guidelines and Law: Clinical Governance Implications for Trusts" (2004) 9 Clin Govern Int J 212

[70] *Civil Liability Act 2002* (NSW) s 5O; *Wrongs Act 1958* (Vic) s 59; *Civil Liability Act 1936* (SA) s 41(5); *Civil Liability Act 2002* (Tas) s 22.

[71] However, legitimate regional variations *within Australia* in widely accepted practice are acknowledged by the courts. See *Vella v Permanent Mortgages Pty Ltd* [2008] NSWSC 5050 at [553-6]

professional opinion defence[72]. This means that overseas practices or treatments that are not yet supported locally, they would likely not qualify for the purposes of determining whether the practitioner has acted in accordance with standard and competent practice, and therefore the practitioner will have no remedy unless the prevailing peer opinion (not to incorporate such treatments) is deemed to be irrational. Whilst in the medical profession this may, potentially, raise problems in relation to the use of emerging or novel therapies, there are even greater ramifications for emerging professions, or for professions whose scope is expanding. For example, physician assistants are commonly utilised as independent primary care practitioners – with a duty of referral for more serious conditions – in countries such as the United States, but have only recently been implemented in Australia[73]. As such, there is little[74] case law and few guidelines in Australia with which to guide what currently constitutes professional opinion. Moreover, as the professional community remains small, it may lack professional capacity and infrastructure and may be reliant on overseas sources (such as journals and conferences) to maintain and improve practice skills. In a small and emerging health profession there may be variable uptake of those skills learnt from overseas sources, particularly from early adopters (and perhaps perversely, from those most interested in improving standards of care by importing skills from countries where scope of practice has been more critically developed) and as such these may not be able to form professional peer opinion for the purposes of civil liability legislation.

Wide acceptance and conflicting opinion

The post-*Ipp* statutory standards impose further restrictions on the standard *Bolam* test, by requiring 'wide-acceptance' and therefore excluding what *Ipp* described as 'extreme views held by few experts' or 'rogue practitioners'[75]. By allowing for *competent* practice, it also ensures that non-evidence based, irrational or out-dated practices can be also be excluded at the court's discretion. In new and emerging professions, or professions who are entering new fields of practice, it may be reasonable to expect conflicting expert evidence regarding both competence and widely accepted practice. In the case of *Dobler v Halverson*[76] the Court of Appeal considered, amongst other matters, the operation of s 5O of the *Civil Liability Act 2002* (NSW) relating to standard of care for professionals. In his decision, Giles JA put forward a mechanism for consideration of conflicting expert evidence regarding competence and widely accepted practice. In this case, the respondent (Halverson) had suffered cardiac arrest and hypoxic brain damage (at the age of 18), and was discovered later to have suffered from Long QT Syndrome, a cardiac condition. The defendant (Dobler) was the respondent's general practitioner. Dobler had been consulted during three of the respondent's previous syncopal events (loss of consciousness), and had found a heart murmur in his examination of the respondent when he had presented for a migraine. Halverson's case was that Dobler, taking into account the previous history, should have considered possible cardiac problems and referred for an electrocardiogram and consultation with a cardiologist. Dobler had appealed a previous ruling awarding the respondent damages, criticising (among other things) the judges reasoning on certain issues based on conflicting expert evidence. However, Giles JA stated that:

> *"the question was not necessarily one of preferring A's evidence of acceptable professional practice to the evidence of B. Rather, if B's evidence supports the manner in which the defendant acted, the question was whether it established professional practice widely accepted by rational peer professional opinion. If both A and B gave their evidence as evidence of whether the manner in which the defendant acted accorded with professional practice widely accepted by rational peer opinion, the question will be one of preferring A's*

[72] See *Hope v Hunter and New England Area Health Service* [2009] NSWDC 307 (27 November 2009) at [170-1]
[73] Health Workforce Australia, n 23 at 1.
[74] None, at least as far as the author can tell
[75] Panel for the Review of the Law of Negligence, n 7 at [3.8]
[76] [2007] NSWCA 335

evidence to that of B, but otherwise it will be one of acceptance of B's evidence, its weight and what it establishes."[77]

In other words, the onus was on all parties to not only show that the doctor acted competently, but also that the way in which the health professional acted was in line with accepted practice. If conflicting evidence does emerge and a higher appropriate standard is put forward as peer professional opinion, the court cannot rely on an expert's own belief that the lower standard put forward is acceptable, but also satisfy the court that such a departure is widely accepted.

Differing opinions may not just present themselves in court, but very different opinions may be within sub-elements of professions, or between academic and clinical opinion[78]. The English case *De Freitas v O'Brien*[79] had demonstrated that even a small minority opinion may be considered valid peer professional opinion for determining accepted practice, if the body of opinion was 'responsible'[80]. Although the post-*Ipp* statutory standards impose further restrictions on the standard *Bolam* test, by requiring 'wide-acceptance' and therefore excluding what Ipp described as 'extreme views held by few experts' or 'rogue practitioners'[81], the lack of specificity in defining health professions within the legislation would suggest that if a practice could be demonstrated as a rational and responsible subspecialty, it may only need to demonstrate wide acceptance within this subspecialty rather than the general field. This may In the Australian setting this was explored by the case *Hawes v Holley*[82], where it was claimed that complications after bowel surgery could have been avoided with less aggressive pharmacological treatment:

"…the two camps … would … be very disparate in size … the number of surgeons who were [not] enthusiastic advocates of [the drug] would be by several orders of magnitude larger than those who espoused this treatment. If one looks at the literature on the [drug] treatment, the vast majority of it comes from physicians, medical doctors, not surgeons … and physicians of course are generally enthusiastic about pharmacological treatments. … there would be a wide body of surgical opinion that would not use [the drug] treatment."[83]

Ultimately the judge found, despite differing expert opinion, that the statutory standard was not required to be applied as there was common ground between both the physician and surgical communities that the drug should not have been used in certain circumstances. Although the trial judge did not indicate whether there was one relevant 'field' for the purposes of peer professional opinion to determine standard of care, he did comment that differing standards were acceptable to the court, provided that they fulfilled the criteria of being rational:

"Finally, a comment should be made about the alleged "two camps" as to the use of neostigmine, the enthusiasts and the non-users. In present respects, I do not think anything relevantly turns on this. Pursuant to s 5O(1) of the Civil Liability Act a professional is not

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[77] [2007] NSWCA 335 at [303]

[78] See *Dr Ibrahim v Arkell* [1999] NSWCA 95 (27 May 1999); *Shead v Hooley* [2000] NSWCA 362 (14 December 2000).

[79] (1995) 25 BMLR 51

[80] See (1995) 25 BMLR 51.This case related to the nascent field of spinal surgery. At the time there were just 11 orthopaedic surgeons and neurosurgeons specialising in spinal surgery, out of a total group of over 1000 practitioners in the general field. Expert evidence accepted that normal medical opinion was that surgery should not be undertaken. However, the Court of Appeal accepted that the conduct of the defendant should be judged by reference to the specialism of spinal surgery. In relation to that subspecialty, the practice complied with the opinion of a responsible body of practitioners within that field. This was in spite of the fact that there was no indication in the case that at that time any of the relevant Colleges recognised spinal surgery as a subspecialty. The English case confirmed that the test refers to a responsible body of opinion, rather than a requirement that it be a substantial body of opinion.

[81] Panel for the Review of the Law of Negligence, n 7 at [3.8]

[82] [2008] NSWDC 147 (22 August 2008)

[83] [2008] NSWDC 147 at [84]

> *negligent if it be established that the professional acted in a manner at the time which was widely accepted by peer professional opinion as competent professional practice. Sub-section (3) of the section acknowledges that there may be differing such opinions so that any one opinion may be relied upon as a defence to an action for negligence. Here, I am satisfied there are differing opinions about the use of neostigmine."*[84]

It therefore also appears to be assumed that the relevant peer opinion is not limited to a defendant's particular specialty or subspecialty and that it was sufficient if peer opinion in a related specialty would have regarded the defendant's practice as competent practice, but not if the relevant peer opinion effectively imposes a different standard of care to the defendant's profession[85]. Sappideen highlights this through the use of the example of a midwife, where negligence involving a home birth and the question is whether a midwife was negligent in allowing the second stage of labour to continue for too long, the relevant peer opinion would be that of midwives not obstetricians[86]. However, this would also be subject to the court deeming the treatment to be rational.

Standards that are divergent from orthodox medical practice

This may even ring true for unorthodox or unproven therapies, for which there is little (scientific) evidence and may reject conventional medical thought. In the English case of *Shakoor v Situ*[87] Livesy J considered the question of whether the same principles applying to Western medical practitioners applied to practitioners of traditional Chinese medicine. In this case a widow of a patient sued a Chinese herbal medicine practitioner after her husband died after a course of herbal medicine treatment for benign lipomata. Although the herbal medicine treatment was, on balance, largely responsible for the patient's death, it was held that this was most likely to have been an idiosyncratic reaction that the practitioner could not have foreseen. However, as part of his deliberation, Livesy J considered the professional standards to which a Chinese herbalist should be held. After considering whether an unorthodox therapist such as a Chinese herbalist should be held to the same standards as an orthodox medical practitioner, he disagreed, stating:

> *"The Chinese herbalist, for example, does not hold himself out as a practitioner of orthodox medicine. More particularly, the patient has usually had the choice of going to an orthodox practitioner but has rejected him in favour of the alternative practitioner for reasons personal and best known to himself and almost certainly at some personal financial cost. Those reasons may include a passionate belief in the superiority of the alternative therapy or a fear of surgery or of reliance (perhaps dependence) on orthodox chemical medications which may have known undesirable side effects either short- or long-term or both."*[88]

It should be noted, however, that Livesy J also noted that peer professional opinion was valid in Chinese medicine because, even though it may not be viewed as a legitimate therapy by many, it adequately demonstrated a body of knowledge, noting "unlike some alternative therapies, [traditional Chinese herbal medicine] has a long and distinguished history; it has an oral tradition extending back some 4,000 years or more and a written tradition extending back some 2,000 years"[89]. He did, however, hold that although the Chinese herbal medicine practitioner was not required to be held to the same standard of care as an orthodox practitioner, as part of the practitioner's scope of practice "it will often be necessary to have regard to the fact that the practitioner is practising his art alongside orthodox medicine"[90]. This was taken to mean that the practitioner both needed to be familiar with medical literature pertaining to Chinese herbal medicine practice (such as adverse events or potential

[84] [2008] NSWDC 147 at [100]
[85] Sappideen C, n 51 at 411
[86] Sappideen C, n 51 at 411
[87] [2000] 4 All ER 181
[88] [2000] 4 All ER 181 at [416]
[89] [2000] 4 All ER 181 at [410]
[90] [2000] 4 All ER 181 at [186]

interactions). These provisions are not unlike the provisions currently included in New South Wales and South Australian legislation relating to unregistered health practitioners, which requires that all unregistered health practitioners – including unorthodox practitioners – be held to the relevant standards within their professional group, but also require them to be familiar with orthodox medical literature and research on safety and ethics issues.

Being held to other professional standards

One possible exception to where a practitioner may be held to the standards of another profession is when that practitioner expands their scope of practice to take on tasks or practices that are largely performed by other professions. This issue was explored in the case *Forder v Hutchinson*[91]. In this case the appellant claimed that the respondent – an osteopath and naturopath – was negligent in failing to advise him of the risks associated with osteopathic manipulation of the neck and in the manner in which the respondent manipulated his neck, which he claimed resulted in vertebra-basilar ischaemic syndrome with resultant pain and suffering. In the initial judgement the trial judge had dismissed the claim on the basis that he was not satisfied on the evidence that the respondent's conduct fell short of the standards of a competent osteopath. Among the principles considered was whether the expert evidence of a chiropractor was relevant to the practice of osteopathy.

In the initial case, a Professor Terrett, a chiropractic academic from RMIT who taught chiropractic techniques to chiropractic, osteopathic and naturopathic students had been called as an expert witness and argued that the standard of care of the respondent fell short of accepted professional practice. The trial judge had dismissed the expert evidence of Professor Terrett, as not being relevant to the practice of osteopathy, stating that:

> "*... I accept Professor Terre[t]t as being an expert in his field, which is chiropractic. The fact that some osteopathic students are lectured to by him does not make him an expert in osteopathy since he did not claim to lecture them in any osteopathic techniques or naturopathic techniques. It follows from that, I believe I can safely conclude that as much as Professor Terre[t]t does with osteopathic students to lecture them about chiropractic techniques, and where insofar as they might coincide at some points with osteopathy [sic]"*[92]

Nettle J claimed that this reasoning was erroneous, noting that chiropractic was a system of health care of which the principles treatment was spinal manipulation, whilst as osteopathy was a holistic approach to health care which embraced a range of treatments, including chiropractic treatment. Therefore, it was considered 'self-evident' that when the respondent manipulated the appellant's neck, he was doing so as an osteopath using a chiropractic treatment. As an academic chiropractic practitioner who had taught chiropractic techniques to osteopathy students, it was held that there "was no dispute that Professor Terrett was qualified to express an opinion on chiropractic treatment by osteopaths"[93]. It should be noted, however, that this referred to whether the standard of practice was *competent*, not whether it formed accepted peer professional opinion.

Potential Impact on professional liability

Health disciplines expanding their scope of practice to take on roles once performed solely by medical professionals – though to a lesser extent other professions as well – will find exposure to potential liability increasing, due to the increased skill level required and the complexity of these tasks. Although increased exposure may add to the case law in this area, it will bring with it further problems for emerging and new professions. For some health disciplines such scope expansion may be not be sustainable, not due to their individual capability (or lack thereof) to perform these tasks, but due to the difficulties of non-medical professions to adequately and sustainably ensure liability

[91] [2005] VSCA 281 (30 November 2005)
[92] [2005] VSCA 281 at [43]
[93] [2005] VSCA 281 at [44]

coverage. A poignant example of this is the Australian midwifery profession, which has had to have specific – though temporary – exclusions from the requirement that all registered health professions "maintain appropriate professional indemnity insurance" under Section 129(1) of the National Law[94]. Whilst hospitals have agreed to provide relevant coverage for hospital midwives, this has created difficulties for independent midwives – those midwives who work as sole practitioners in a business owned or operated by themselves or other midwives – in obtaining "appropriate" levels of insurance[95]. Although it is likely that insurers would be able to grant cover for the full scope of independent midwifery practice (though none currently do), risk analysis dictates that they are unable to do so at a price that would be practical or feasible for that profession[96]. Interim transitional arrangements have been developed which exclude midwives from this requirement[97], though these arrangements are temporary. In this instance, withdrawal of this exclusion would not legally reduce the scope of independent midwifery services that could be provided competently by midwives, but they would have 'real world' scope reduction by virtue of the fact that such services would, likely, be rendered financially unviable. In such a scenario, some midwives may choose to continue to provide independent midwifery services either as midwives (or as unregistered birth attendants)[98] without appropriate insurance arrangements in place. In these instances accepted professional standards under civil liability may not relate to whether the practitioner has the technical skills to practise the health service competently, but rather the failure of the practitioner to abide by relevant obligations to the practice of their health service[99].

Conclusion

One of the potential issues of expanded scope for health practitioners poses for the medical litigation is the hesitance of modern governments to expand regulatory arrangements for health practitioners. Historically, this may have limited who the term 'professional' may have applied to in relation to the provision of health services, yet legislative trends indicate that the term is increasingly used as an inclusive definition, bringing all persons who practice a health service via the application of a body of knowledge within the realms of civil liability legislation – a term more closely aligned perhaps with the previous use of 'occupation'. For emerging or 'unorthodox' professions, however, the broad definition employed in the post-*Ipp* arena would seem to be inclusive enough to incorporate them, and therefore allow them to dictate their own standards, and when practitioners deviate from them. This would seem to be particularly relevant as Australian governments, beginning with New South Wales and South Australia[100], also begin to target the health practice of unregistered practitioners through 'negative licensing' arrangements such as statutory codes of conduct, which require a broad,

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[94] It should also be noted that under national negative licensing arrangements, this is also likely to be extended to unregistered health practitioners, as it is in New South Wales and South Australian legislation relating to unregistered practitioners.

[95] Forrester K, "Nurses, midwives and the requirement for "appropriate" professional indemnity insurance" (2012) 19 JLM 678

[96] For example, high costs of liability insurance, which were unable to be adequately recouped through personal services income, was a major factor behind general practitioners in Australia ceasing their role in obstetric care, even when these practitioners were suitably trained and otherwise willing to perform these services. See Innes K and Strasser R, "Why are general practitioners ceasing obstetrics?" (1997) 166 Med J Aust 276

[97] These are under the *Midwife Professional Indemnity (Commonwealth Contribution) Act 2010* (Cth)

[98] One South Australian midwife – Lisa Barrett – has already attempted to circumvent these provisions by de-registering as a midwife and continuing to provide birth care as an unregistered practitioner, and has had a prohibition order issued against her under that State's new negative licensing legislation. See South Australian Health and Community Services Complaints Commissioner, *Statement for Public Release: Lisa Barrett* (28 November 2013), http://www.hcscc.sa.gov.au/wp-content/uploads/2013/12/011122-signed-public-statement-and-s56-order-28-Nov-13.pdf

[99] The negative licensing legislation in New South Wales and South Australia, and proposed for national roll-out, has a requirement that anyone providing a health service maintain adequate professional indemnity insurance. See *Nursing & Midwifery Board of Australia v Barrett* [2014] SAHPT 1 (11 March 2014) where a midwife who sought to remove herself from registration and practice as an unregistered practitioner without insurance.

[100] But also to be rolled out nationally

expansive and inclusive definition of ‘health professional’ to enable statutory authorities to have jurisdiction over unregistered practitioners.

This broader definition may be create some complexities, as many new, emerging or unregistered professions have not undergone traditional professionalization pathways in which their body of knowledge has been codified and documented. However, even in these ‘professions’, the individual health profession have relative autonomy to define their accepted standards within their profession. However, these standards are influential, but not conclusive, in the post-*Ipp* modified *Bolam* test. However, legislation even for unregistered practitioners contains statements that all practitioners must ‘provide health services in a safe and ethical manner’, which is described as practising within the scope of their knowledge and training, maintaining expertise and competence in their respective field, and only practising their service in the interests of their client. Moreover, the courts may reject professional opinion if it is considered to be irrational. Additionally, whilst individual professions do have autonomy in developing their own practice standards, it appears that all professions are required to consider safety and risk in similar frameworks. Therefore, whilst individual professions do have ultimate discretion in determining what a deviation from standard accepted, and even competent practice, the onus remains on experts, and the profession more generally, to demonstrate that this practice is rational. If they are unable to do so, even widely accepted professional practices are unlikely to serve as adequate defences in civil liability suits.